

FILED OCT 11 1944

Registration District No. _____

Primary Registration District No. 3000

Registrar's No. 243

1. PLACE OF DEATH:

(a) County Adair
(b) City or town Ricksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Community Nursing Home
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4
(Specify whether years, months or days) five years

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo (b) County Adair
(c) City or town Ricksville
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

3. (a) PRINT FULL NAME Lillian Yates

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

5. Color or race W
6. (a) Single, widowed, married, divorced W
(b) Name of husband or wife Eugene Brown 6. (c) Age of husband or wife if alive, _____ years
(Day) (Year) 15 1865

8. AGE: Years 79 Months 7 Days 18
If less than one day hr. _____ min. _____

9. Birthplace _____ (City, town, or county) _____ (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Henry Wahlen
13. Birthplace _____ (City, town, or county) _____ (State or foreign country)
14. Maiden name Bontrose
15. Birthplace _____ (City, town, or county) _____ (State or foreign country)

16. (a) Informant Manager, Hospital and
(b) Address Ricksville, Mo. Adair
17. (a) Burial (b) Date thereof 9/6/44
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation Maple Hill Cemetery

18. (a) Signature of funeral director Sumner Towell
(b) Address Ricksville, Mo
19. (a) 9-7-44 (b) Mrs. J. L. Wagner
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Sept day 3
year 1944 hour 10 minute 45 A. M.

21. I hereby certify that I attended the deceased from May 2
_____, 1944, to Sept 3, 1944.
that I last saw her alive on Sept 3, 1944,
and that death occurred on the date and hour stated above.

Immediate cause of death Acute ventricular failure 2 min
Due to Chronic Myocarditis years _____
Due to _____

Other conditions (Include pregnancy within 3 months of death)

Major findings:

Of operations _____
Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) _____ (County) _____ (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? _____ (Specify type of place) (e) Means of injury _____
Signature M. T. Suterash (M.D. or other) DO
Address Ricksville, Mo Date signed 9-5-44

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

RECEIVED

District Health Officer No. 10

District File Number 10-44-1710

Date Filed OCT 10 1944

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____
_____, Registered Apprentice No. _____,
working under my personal supervision.

Signed

W. C. Summers

Licensed Embalmer No.

2159

P. O. Address

Riversville Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.